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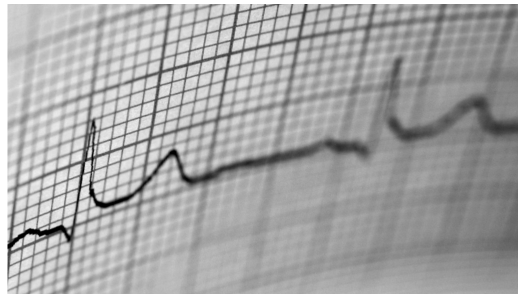
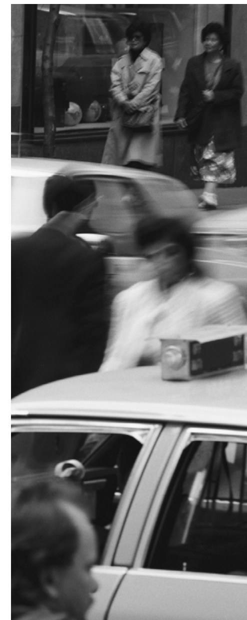
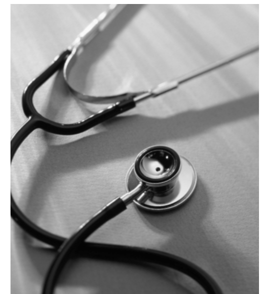
The Patient-Centered Medical Home: Taking a Model to Scale in New York State



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The Patient-Centered Medical Home: Taking a Model to Scale in New York State

Gregory Burke

UNITED HOSPITAL FUND

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Foreword

Central to the Fund's work are our efforts to identify, understand, promote, and share innovations that promise to transform health care in New York. Across the state, providers and payers are testing new ways of delivering and financing care that have the potential to make a real and sustainable difference in improving the quality of care and the patient and family experience of care, and in reducing the increase in the costs of care. This report, *The Patient-Centered Medical Home: Taking a Model to Scale in New York State*, is an example of the Fund's focus on innovation.

Written by Gregory Burke for a recent and productive statewide invitational conference (co-sponsored by the Fund, the Primary Care Development Corporation, and the New York Chapter of the American College of Physicians), this report provides important insights into the implementation of a new model of primary care, the patient-centered medical home (PCMH).

This is the third in a series of reports focused on this model of care. The previous two reports, *A Multipayer Approach to Health Care Reform* (2010) and *The Adirondack Medical Home Demonstration: A Case Study* (2011), explored pioneering efforts to spur health care system change in the Adirondack region.

This report describes the PCMH model's core elements and examines its effectiveness, particularly in improving the care of patients with chronic diseases, whom the current health care system serves least well. It also documents the notable expansion of patient-centered medical homes through pilots and demonstrations being conducted by providers and payers in communities across New York State. The report concludes with an examination of a series of key issues relevant to the model's further expansion in the state, from the perspective of patients, providers, and payers.

Our work related to patient-centered medical homes is an example of the Fund's commitment to promoting positive change by sharing good ideas and workable solutions with health care leaders and stakeholders to help shape public policy that can help accelerate meaningful innovation statewide.

JAMES R. TALLON, JR.
President
United Hospital Fund

Acknowledgments

This report was prepared as background for a statewide invitational conference on the patient-centered medical home, organized at the request of the New York State Health Commissioner, Nirav Shah, MD, MPH. It is based on research and interviews conducted during summer and fall of 2011 with leaders involved in the development and operation of the many medical home demonstrations now under way across New York State, who were extraordinarily generous with their time. What is right in this report is, in the main, based on their thoughts and insights.

The provider profiles presented in this report are the result of analyses conducted by the author, based on data provided by the New York State Office of Health Insurance Programs, the New York State Center for Health Workforce Studies, and the National Committee for Quality Assurance (NCQA), all of whom were extremely helpful in generating, sharing, and helping to interpret those data.

This paper benefited greatly from the ongoing input by the Planning Group that organized that conference, including John Rugge, MD, from the Hudson Headwaters Health Network; Foster Gesten, MD, from the New York State Office of Health Insurance Programs; Ronda Kotelchuck, Dan Lowenstein, and Jennifer Chen from the Primary Care Development Corporation; Linda Lambert and Lisa Noel from the New York chapter of the American College of Physicians; Melinda Abrams from the Commonwealth Fund; and my colleagues Jim Tallon and David Gould from the Fund. One could not have chosen a better, more expert group with whom to work and from whom to learn, or one more committed to realizing the potential of the medical home to improve the health of the people of New York State.

This report was supported in part by the New York Community Trust and EmblemHealth.

Introduction

As the movement toward health reform advances, attention is expanding from a focus on the reform of the insurance system to include the imperative that we improve the performance of the health care delivery system. One of the clearest articulations of that agenda is the Institute for Healthcare Improvement's "Triple Aim," which calls on providers to:

- improve health care quality, and improve the health of the populations being served;
- improve the experience of care for patients and providers; and
- contain costs, and reduce them when possible. (IHI 2011)

Beyond the focus on improving the performance of the delivery system as a whole, there is a growing sense of urgency in the need to better manage the costs of health care, and, in particular, to improve the care of specific high-cost subpopulations who account for a disproportionate share of health care costs — the 20 percent who account for 80 percent of the costs. This group includes people with multiple complex chronic conditions, patients receiving long-term care services, and those nearing the end of life — patients for whom the acute-care-oriented payment and delivery systems work least well.

Over the past five years, a new model of primary care delivery and financing has emerged, gaining the attention of providers, payers, and policymakers because it has the potential to address changes needed both system-wide and for high-cost populations. This innovation, the Patient-Centered Medical Home (PCMH), has great promise as a way to address some of the major problems identified in the delivery of primary care, improving access, prevention, quality, and coordination, as well as the experience of care for all patients, and setting up systems and staff to manage better the quality, continuity, and costs of care for the most complex, highest-cost subpopulations of patients.

The PCMH model has been increasingly embraced by both providers and payers in New York State. New York is, in fact, among the nation's leaders in developing and supporting this new care model, with demonstration projects across the state that are beginning to produce measurable results.

The purpose of this paper is:

- to describe the PCMH model, its basic components, and what appear to be its "active ingredients";
- to describe how the adoption and implementation of the PCMH model is playing out in communities across New York State, noting some of the quite different ways in which those experiments are being developed and funded; and
- to highlight some of the policy and pragmatic issues related to that implementation, identifying some of the key drivers and enablers of that proliferation, and some of the impediments and challenges now being faced by providers and payers.

Overview of the Patient-Centered Medical Home

Background

In March 2007, the four major primary care physician societies (the American Academy of Pediatrics, the American College of Physicians, the American Academy of Family Physicians, and the American Osteopathic Association) developed and published the Joint Principles of the Patient-Centered Medical Home.

These principles have been widely accepted as a framework for defining the characteristics of a redesigned primary care practice, the PCMH. Over the past four years, these principles have been used by a variety of organizations as the starting point for the development of increasingly specific descriptions, standards, and criteria for defining, certifying, accrediting, and recognizing primary care practices as PCMHs.

What a PCMH Does: Major Points of Intervention and Change

The process of moving from a traditional primary care model driven by fee-for-service (FFS) to one based on the precepts of the PCMH model is known as "practice transformation." The name is an apt one, since the process represents several major changes in the way a traditional primary care practice is structured and operates, as well as the addition of some new functions. Some of the basic elements of practice transformation include:

- creation of practice teams, with new roles for existing staff and the primary care physician;
- changes in operating hours and the implementation of "advanced access" scheduling to improve patient access and enable the routine scheduling of same-day visits;

Excerpt from the *Joint Principles of the Patient-Centered Medical Home*

Personal physician - each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

Physician directed medical practice – the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

Whole person orientation – the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.

Care is coordinated and/or integrated across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

Quality and safety are hallmarks of the medical home: Evidence-based medicine and clinical decision-support tools guide decision making.

Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.

Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home.

Source: http://www.pcpcc.net/content/joint-principles-patient-centered-medical-home

- changes in the content of the visit, reorganizing work (and staff roles) into "pre-visit" preparation, focused attention to open issues during the visit itself, and post-visit counseling, support and teaching, and follow-up;
- acquisition and use of electronic medical records, including prompts and alerts that reinforce evidence-based practice, charting, making and tracking referrals and test results, and electronic prescribing, as well as having access, through regional data exchanges, to clinical information from other providers;
- a renewed focus on care coordination, and close attention to care transitions, particularly for patients being discharged from hospitals;
- development and use of "patient portals," through which patients and their families can communicate with members of the care team, without the need for a visit; and
- implementation of new processes for quality improvement, including the regular measurement, review, and external reporting of specific quality metrics.

In addition, the PCMH model requires a practice to put into place an infrastructure focused on managing populations of patients with chronic diseases, which entails new functions, new staff, and new operating costs for the practice. PCMHs need to have registries to identify and track the status and care of patients with specific clinical problems (such as diabetes or heart failure) to be able to stratify these populations into risk groups and to provide targeted, patient-centered programs of case and care management to high-risk individuals. Lastly, they need to have in place programs of patient health education, self-management training, and patient engagement, as well as consulting arrangements with pharmacists (often PharmDs, doctors of pharmacy) for issues of medication management.

For a primary care practice to transform its operating model to a PCMH is a significant undertaking. In addition to disrupting the practice's basic operating model, it involves a substantial investment in implementing new operating systems and staff roles; in the acquisition, implementation, and training in the use of electronic medical records; and in the development of a series of new functions related to population health management.

The amount of change and disruption required for a practice to achieve recognition as a PCMH — and the level of investment required to do so — varies from practice to practice, depending on the capacities already in place. If the basic capacities of a PCMH (e.g., electronic medical records, staff organized into care teams, and organized processes for quality improvement, data collection, and reporting) are already in place, a practice can make the transition with less disruption and cost.

The same is true for the infrastructure required for population health management: registries, systems, and staff competent in care management, patient education, patient engagement, and self-management training. Practices also vary in the availability of investment capital to fund the required changes, reserves or working capital enabling the practice to absorb the likely drop in productivity and income during the transformation into a PCMH.

The ability for a practice to put into place these capacities also depends somewhat on its organizational structure, which can range from a solo practice to a large and sophisticated multi-specialty group. In general, it is easier for primary care practices that are part of larger organizations (which have an administrative, clinical, and information technology infrastructure, scale, and more resources) to become PCMHs. This tends to advantage multi-specialty groups,

federally qualified health-centers (FQHCs), hospital-based practices, and providers who have banded together under an independent practice association (IPA) or shared-services structure.

In general, hospital clinics have more difficulty in making the transition to a PCMH model of care because most operate as teaching clinics, in which the logistics of the teaching program complicate their operations as primary care providers.

The Value and Benefits of PCMHs

Effective, high-performing primary care providers and systems that can manage populations of patients (particularly the medically complex and chronically ill, who generate most of the "preventable" utilization and cost) are critical to the success of health reform. Capacities like those of the PCMH have been cited as the foundation of a high-performing health system (Shih et al. 2008) and are core competencies for any provider system proposing to assume population-based risk under vehicles such as the accountable care organization (Guterman et al. 2011, Rittenhouse et al. 2009).

The PCMH has shown particular value in the management of patients with complex, chronic diseases — a population that historically has received less than optimal quality and continuity of care, and has had poor experiences of care (patients and family members alike) and high levels of "preventable" hospital admissions (Robert Graham Center 2007).

The PCMH has the potential to greatly improve the performance of a primary care practice for all the patients it serves by the application of team-based care, expanded access, the use of registries, and care managers; through systems that support, measure, and improve application of evidence-based approaches to chronic disease management (the Chronic Care Model is central to the PCMH); and through the use of established techniques of patient engagement and self-management training (AHRQ 2008).

There is a growing literature reporting on the success of the PCMH in improving quality of care, improving the experience of patients and providers as well, and reducing "preventable" utilization and costs. (Grumbach, Bodenheimer, and Grundy 2009; Grumbach and Grundy 2010).

The methodologies used in those studies have varied, but most have used commonly accepted metrics: Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) to measure patient experience, various Healthcare Effectiveness Data and Information Set (HEDIS) measures to measure quality, and emergency department and hospital utilization measures as a proxy for cost. Many have shown that the implementation of the PCMH model has made measurable positive changes in each domain.

However, many evaluations of PCMHs across the country (and across New York) are still in progress; and although the evidence is trending positive, there is not yet an evidence-based consensus on the part of all providers, payers, purchasers, or government bodies on its value or impact. There is a need for clear, compelling, and unambiguous evidence that the PCMH model really works.

Certification Processes for PCMHs

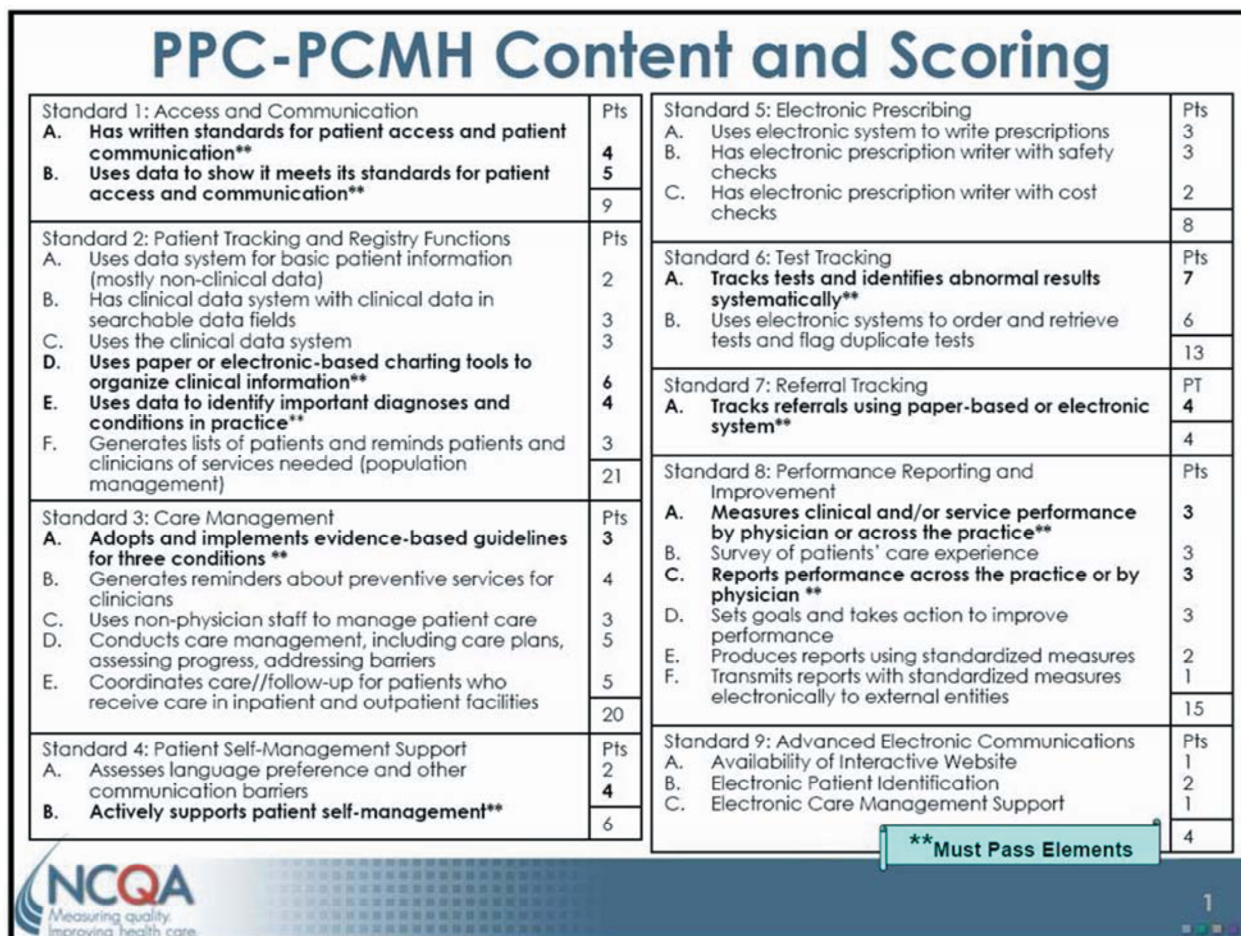
It has been essential for both providers and payers to have a clear set of standards for defining a PCMH, and to have an impartial, expert, external body able to judge which providers are (and are not) in compliance with those standards, able to formally accredit or certify a provider as a PCMH. Providers need to have specific criteria identifying the capacities that they need to put into place, capabilities that are measurable and can be verified. Payers benefit from having an external body that formally defines the "product" they are purchasing and supporting.

The first and most widely accepted of the "medical home" certification processes was the Physician Practice Connections® – Patient-Centered Medical Home™ program (PPC®-PCMH™) developed by the National Committee for Quality Assurance (NCQA), which was the early leader in establishing specific standards, criteria, and a process for "recognizing" primary care practices as PCMHs. NCQA's 2008 standards and recognition process required practices and providers seeking NCQA recognition as a PCMH to certify adherence to a set of principles and to submit detailed information documenting the ability to meet 30 specific elements, organized under nine standards (see below).

In NCQA's recognition process, certain key elements are identified as "Must Pass" capacities and all elements are assigned numerical scores, which together determine whether a given practice receives NCQA recognition as a PCMH at Level 1, Level 2, or Level 3.

Level 3 is NCQA's highest level of recognition, given to practices that meet all of the key elements and achieve a specific aggregate score. Although use of electronic medical records (EMRs) is not

Figure 1. **Patient-Centered Medical Home Standards**
(Screen Shot from NCQA Website)



PPC-PCMH Content and Scoring

Standard 1: Access and Communication	Pts
A. Has written standards for patient access and patient communication**	**4**
B. Uses data to show it meets its standards for patient access and communication**	**5**
	9
Standard 2: Patient Tracking and Registry Functions	Pts
A. Uses data system for basic patient information (mostly non-clinical data)	2
B. Has clinical data system with clinical data in searchable data fields	3
C. Uses the clinical data system	3
D. Uses paper or electronic-based charting tools to organize clinical information**	**6**
E. Uses data to identify important diagnoses and conditions in practice**	**4**
F. Generates lists of patients and reminds patients and clinicians of services needed (population management)	3
	21
Standard 3: Care Management	Pts
A. Adopts and implements evidence-based guidelines for three conditions **	**3**
B. Generates reminders about preventive services for clinicians	4
C. Uses non-physician staff to manage patient care	3
D. Conducts care management, including care plans, assessing progress, addressing barriers	5
E. Coordinates care//follow-up for patients who receive care in inpatient and outpatient facilities	5
	20
Standard 4: Patient Self-Management Support	Pts
A. Assesses language preference and other communication barriers	2
B. Actively supports patient self-management**	**4**
	6

Standard 5: Electronic Prescribing	Pts
A. Uses electronic system to write prescriptions	3
B. Has electronic prescription writer with safety checks	3
C. Has electronic prescription writer with cost checks	2
	8
Standard 6: Test Tracking	Pts
A. Tracks tests and identifies abnormal results systematically**	**7**
B. Uses electronic systems to order and retrieve tests and flag duplicate tests	6
	13
Standard 7: Referral Tracking	PT
A. Tracks referrals using paper-based or electronic system**	**4**
	4
Standard 8: Performance Reporting and Improvement	Pts
A. Measures clinical and/or service performance by physician or across the practice**	**3**
B. Survey of patients' care experience	3
C. Reports performance across the practice or by physician **	**3**
D. Sets goals and takes action to improve performance	3
E. Produces reports using standardized measures	2
F. Transmits reports with standardized measures electronically to external entities	1
	15
Standard 9: Advanced Electronic Communications	Pts
A. Availability of Interactive Website	1
B. Electronic Patient Identification	2
C. Electronic Care Management Support	1
	4

**Must Pass Elements

NCQA
Measuring quality.
Improving health care.

1

Source: National Committee for Quality Assurance. http://www.ncqa.org/tabid/631/default.aspx (accessed January 19, 2011).

formally required for Level 3 recognition, in practice it is essential.

Because NCQA is a reputable national organization with a long history of effective involvement in programs of quality improvement, and because it was an early leader in the certification of PCMHs, its 2008 standards and recognition process have been widely adopted and are used by most of the country's PCMH demonstrations and pilot projects, including those operating in New York State. In this paper, we use NCQA's 2008 standards and recognition process as the measure of PCMH adoption in New York State.

While NCQA's standards and recognition process has been the most widely accepted definition of a PCMH, there are alternative processes for certification and accreditation of medical homes. In recent years, new accreditors have emerged, some state-based (e.g., in Michigan, Minnesota, and Oklahoma) and some emanating from national organizations: The Joint Commission's Primary Care Home, URAC's Patient-Centered Health Care Home, TransforMED's Medical Home IQ, and The Center for Medical Home Improvement's Medical Home Index (Burton, Devers, and Berenson 2011). Each of these has a slightly different set of standards and accreditation processes, which may lead to some definitional confusion in the future.

In addition, NCQA recently issued a new set of 2011 PCMH standards, which change somewhat the scoring emphases for NCQA recognition, placing more weight on care management and population health (Burton, Devers, and Berenson 2011). In the near term, this also may result in some disagreement and confusion as to what a PCMH is and does.

These programs have much in common, but there are differences among them in content and emphasis. This, coupled with the different processes each uses for accreditation, may lead to some confusion over the next few years in defining what a "medical home" is.

The Importance of Information Technology

Information technology is central to the implementation of the PCMH, and to the collection and reporting of information related to clinical and operational performance. A PCMH depends on EMR systems and improved practice management systems to support improvements in quality and safety, to help them manage team-based care, and to monitor the quality and continuity of care they provide to patients and populations. They also need new business systems to operate under payment systems based on patient acuity and risk scores.

Advances in information technology, including EMRs and claims data management, have also made it possible to measure and report on the care given by specific providers to specific patients and populations, in order to profile their processes of care and outcomes (variously measured) and compare these with industry standards and benchmarks. These data can identify variation, in order to target quality improvement efforts and to drive performance-based incentive payments. These capacities are central to measuring the impact of the PCMH, and to paying for it, either directly or through incentive payments.

Paying for PCMHs

The PCMH model is not well supported by the existing FFS payment system, which underpays primary care in general, and which does not pay for services that are central to the PCMH model, such as care coordination, care management, and patient education.

As noted in the *Joint Principles of the Patient-Centered Medical Home*, there is an expectation that a new model of payment is required for the PCMH, a new payment system that "appropriately recognizes the added value provided to

patients who have a patient-centered medical home."

The rationale for these redesigned payments is twofold. First, in order to achieve NCQA recognition as a PCMH, providers must make investments in the structure and function of the primary care practice and will incur higher operating costs, which should be recognized and supported. Second, the PCMH is expected to be effective in managing patient populations (particularly in reducing preventable hospitalizations by the chronically ill), yielding savings that the payers could and should share with the PCMH providers.

Several different payment approaches are being used in PCMH demonstration projects across the country (Berenson and Rich 2010), including variations on the current fee-for-service payment system and the creation of new risk-adjusted capitation payments. The most prevalent payment approach uses a three-part method to pay participating primary care practices:

- maintaining the traditional FFS billings for face-to-face visits to cover patient-specific expenses and to discourage underuse;
- adding to that a per-member per-month (pmpm) payment, often based on the level of NCQA recognition, to cover the cost of the care management infrastructure ("care management payments"); and
- instituting pay-for-performance incentives based on the provider's achievement of specific, stated goals in quality improvement (currently, largely process measures), improved patient experience, and the reduction in utilization and costs of care.

However, this three-component payment approach is not uniformly accepted or used across all PCMH pilots and demonstrations. Different payment schemes are being used in demonstration projects nationally and within New York State. Some provide substantially higher "care management" payments but *only* for the complex, chronically ill cohort; some use entirely new arrangements that replace FFS payments with risk-based capitated payment systems recognizing and paying substantially more for higher-risk, higher-cost patients.

PCMH: Growth and Current Status in New York State

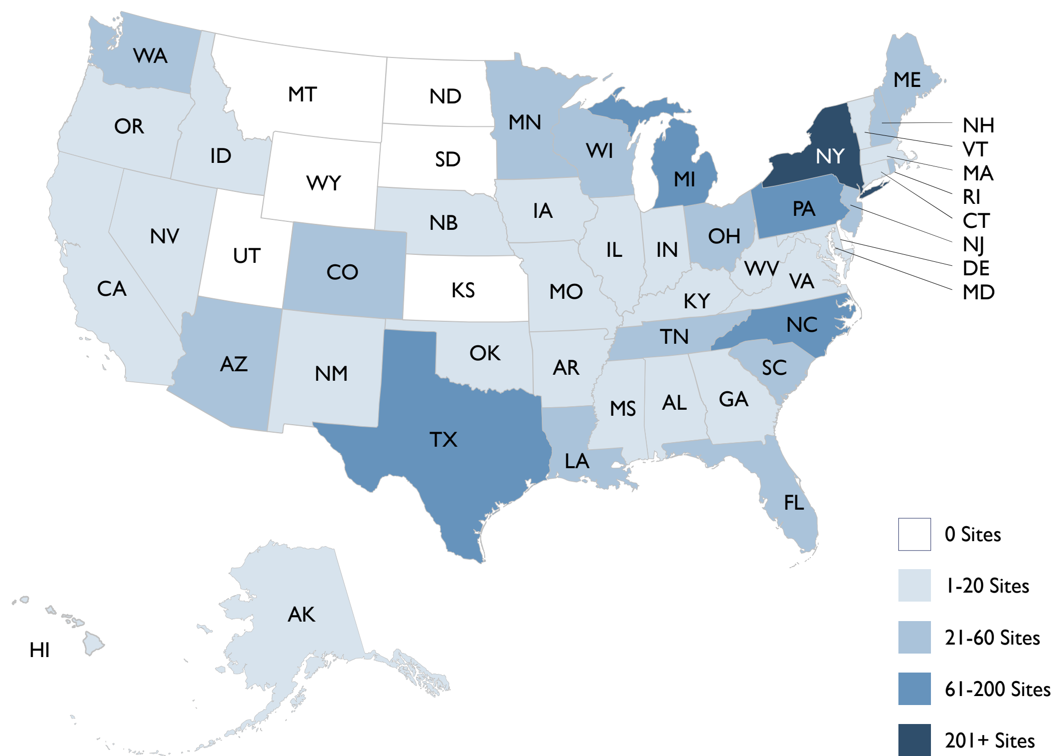
Over the past four years, PCMH pilots, demonstrations, and mainstream payer-provider collaborations have expanded rapidly; federal and state governments have provided leadership and support to the model under Medicare and Medicaid; and, increasingly, mainstream private and commercial payers have begun to adopt the PCMH model as being of value to them and to change the way they are paying for care delivered in a PCMH.

New York State is among the nation's leaders in adopting and implementing the PCMH model in primary care delivery, and New York's payers are among the nation's leaders in adopting and implementing new payment methods for primary care delivered by PCMHs.

As seen in recent presentations by NCQA, New York State leads the nation in the number of NCQA-identified PCMH pilots currently under way and in the number of providers and practices that have pursued and achieved NCQA recognition (Figure 2).

The recent expansion in the number of practices and providers in New York receiving NCQA recognition as PCMHs has been extraordinary. Three basic forces have driven that growth. First, commercial payers, providers, and provider groups across the state have

Figure 2. **NCQA-Recognized PPC-PCMH Sites**



Note: 1,506 PPC-PCMH sites nationwide as of December 31, 2010.
Source: NCQA's Patient-Centered Medical Home (PCMH) 2011. Available at www.ncqa.org (accessed October 6, 2011).

undertaken a number of pilot and demonstration programs implementing the PCMH model with ongoing evaluation of its impact on quality, cost, and patient experience. Second, on July 1, 2010, New York State's Medicaid program implemented changes in its payment system to reward providers who have achieved NCQA recognition. Third, providers across the state who are not involved in the various demonstration programs — but who are anticipating changes in future payment systems — have pursued and achieved NCQA recognition.

This section looks at these three forces, and how they have played out differently across the state, and at their individual and aggregate impact on New York's primary care delivery system.

Pilots and Demonstrations

Over the past four years, providers and commercial payers in New York have been working together to establish PCMH demonstration projects in communities across the state. According to a report by the Rockefeller Institute (Burke and Weller 2010) there were nine such demonstrations in New York State, as of September 2010:

- Adirondack Medical Home Demonstration (AMHD), in the eastern Adirondacks
- Capital District Physicians' Health Plan (CDPHP), in the Capital Area
- Catholic Medical Partners (CMP), in Buffalo
- EmblemHealth, in the New York metropolitan area
- Empire Blue Cross/Blue Shield, also in the New York metropolitan area
- Excellus and MVP, in Rochester
- Independent Health, in Buffalo
- MVP Health Plan, in Syracuse/Onondaga County
- Taconic Health Information Network and Community (THINC), in the Hudson Valley

In addition, while not technically a "PCMH demonstration," there is a third initiative under way in the Buffalo area that is also involved in the PCMH movement: the P² Collaborative, a broad-based community health and performance improvement effort in western New York, involving health providers, payers, local businesses, and community groups. The P² Collaborative is one of 15 communities in the country selected by the Robert Wood Johnson Foundation to be an Aligning Forces for Quality (AF4Q) community. Working closely with HEALTHeLINK (the regional health information organization), which received a $15 million federal Beacon Communities grant, the P² Collaborative is providing essential support to practices in eight counties in western New York, enabling them to improve their performance and to put into place many of the required elements of the PCMH.

These demonstrations are experiments conducted in real-world settings. All have the same basic goals: to improve the performance of their communities' primary care system by implementing the PCMH model in existing practices, and to assess the impact of the PCMH on quality, cost, and patient experience.

All of these demonstrations use NCQA recognition as the threshold for provider participation, but beyond that, they are very different projects. They vary widely in size and scope, and they are taking place in very different communities, serving very different populations. Some are single-payer initiatives, and some are multipayer efforts, and each is using a different method of payment, and different ways of measuring, reporting, and rewarding performance.

There are currently PCMH demonstrations under way in 32 of New York's 62 counties. Many of the state's major payers are involved in these

projects, and some payers are involved in more than one. The table below presents an overview of these demonstrations, describing each in terms of the geography and patient population served, the participating providers and payers, and some of their points of similarity and difference.

Table 1. **New York State Medical Home Pilots: Overview**

	# Physicians	# Practices	# Patients	Payers Involved	Counties/Boroughs Included
Adirondack Medical Home Demonstration	100	33	135,000	BSNENY, CDPHP, Empire BC, Empire Plan (United), Excellus, Fidelis, MVP, Medicaid, and Medicare	Clinton, Essex, Franklin, Hamilton, Warren, and parts of Saratoga and Washington
CDPHP	274	75	100,000	CDPHP	Albany, Columbia, Dutchess, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Ulster, Warren, and Washington
CMP (CIPA WNY IPA)	115	32	N/A	Payers are supporting CMP's Clinical Integration (CI) efforts, broadly. No specific funding for PCMH; it is included in overall funding for CI initiatives	Erie and Niagara
EmblemHealth	64	32	12,000	EmblemHealth	Bronx, Brooklyn (Kings), Manhattan (New York), Queens, Staten Island (Richmond), Nassau, and Suffolk
Excellus/MVP	21	7	33,000	Excellus and MVP (Note: Every patient in participating practices is included in pilot, regardless of insurance status)	Monroe
Hudson Valley	305	15	500,000	Aetna, CDPHP, Empire BC, Hudson Health Plan, MVP, and United	Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, and Westchester
Independent Health	130	18	40,000	Independent Health	Erie, Niagara, and Chautauqua
MVP - Onondaga	50+	21	850	MVP	Onondaga
Anthem/Empire BCBS	260	86	34,000	Anthem/Empire BCBS	Bronx, Brooklyn (Kings), Manhattan (New York), Queens, Staten Island (Richmond), and part of Westchester

Single-Payer vs. Multipayer Demonstrations

One of the primary distinctions among the various demonstrations is whether they are single-payer projects (initiated, sponsored, and operated by a single payer), or multipayer programs, in which multiple payers in a given region are all providing PCMH payments to an organized group of participating providers. The majority of the demonstrations now under way in New York represent single-payer approaches; the Excellus/MVP PCMH demonstration in Rochester involves two payers, but was payer-initiated. Only three (Adirondack, Hudson Valley, and CMP/Buffalo) represent multi-provider/multipayer efforts.

Provider Organizational Model

A second, related distinction is in the way providers have organized themselves to participate in the demonstrations. In the payer-initiated projects, the participating providers interact individually with the payer. In the multi-provider/multipayer demonstrations, participating providers have delegated this activity to an intermediary body (an IPA, or a "shared-services" organization), enabling them to work with the payers collectively.

In the Adirondacks, for example, the providers participate through geographically distinct "pods" and the Adirondack Health Institute (Burke and Cavanaugh 2011). In the Hudson Valley and in CMP/Buffalo, they are using pre-existing bodies — a regional health information organization and an IPA.

In addition to using their intermediary to work with the payers on issues of PCMH demonstration design, conduct, and payment, providers in the multi-provider, multipayer initiatives also use those vehicles to provide a series of PCMH-critical functions and services, such as information technology (IT) consulting, "practice transformation" consulting, and staff and support for care management, health education, and patient engagement, which they "embed" in the practices. The intermediary develops and produces these services, and offers them to the participating practices, either at no cost or by charging the practices for those services under an agreed-upon pmpm arrangement.

Funding for IT and Start-up Costs

Another distinction among the demonstration projects is the source and manner of funding for IT, which is a foundation for the PCMH, and for the start-up costs involved in the practice transformation required to achieve PCMH recognition.

Information Technologies. While certain practices (particularly the large groups) funded their own EMR systems, in many demonstrations government grants provided a substantial portion of the capital required to acquire and install EMR systems in the participating practices, to create regional data exchanges, or both.

Funds provided under the HEAL-NY program were enormously important in developing these capabilities statewide. In New York City, additional assistance was provided to small practices and health centers under the Primary Care Information Project (PCIP), which was important in bringing EMRs and advanced practice capacities to those providers, many of which are essential safety-net providers for the city's underserved.

Practice Transformation. Funding the start-up costs of practice transformation varied substantially among the demonstration projects. In a number of the demonstrations, grant funds from the HEAL-NY program (HEAL-5, HEAL-10, and HEAL-17, the last two focused specifically on improving population health using the "medical home" model) have provided essential support for practice-level clinical transformation. In others, support from private sources and foundations (the Adirondack demonstration, for example, received $3

million from the Medical Society of the State of New York to assist in that program's start-up) has been essential.

In addition, in a number of the demonstrations, participating payers have provided specific, targeted funding

Table 2. **New York State Medical Home Pilots: Financing and Payment**

	Start-up Financing	Operating Payments	Incentive Payments
Adirondack Medical Home Demonstration	Grant funding ($7 million, HEAL-10; $3 million from MSSNY), plus payer support during initial phase. Payers provided $7 pmpm for all members attributed to participating practices to help with practice transformation, in advance of NCQA recognition	$7 pmpm care management fee for all members in participating practices that have achieved NCQA recognition as Level 2 or 3 PCMH	Incentives for quality, patient experience, and efficiency are planned for out-years, once baseline measures and measurement/ reporting systems are in place
CDPHP	CDPHP funds practice transformation in participating practices in "Phase 1"	In "Phase 2," after practices have achieved NCQA recognition, CDPHP re-contracts with participating physicians/practices, changing payments to a risk-adjusted capitation	Incentives for quality, patient experience, and efficiency apply in Phase 2
CMP (CIPA WNY IPA)	CIPA provides technical assistance, training, and a start-up monthly stipend to the practice for 9 months to cover administrative functions	Support for care coordination role, clinical and IT assistance, and a monthly capitation (pmpm) payment for the practice if the practices achieves Level 3	Payment for patient surveys, and an additional payment for performance on quality measures
EmblemHealth	N/A	$2.50 pmpm paid to physicians based on severity of risk of physician's panel and their NCQA recognition level achieved (i.e., combined payment for PPC-PCMH recognition and care management)	$2.50 pmpm (patient experience and quality measures combined)
Excellus/MVP	Excellus BCBS and MVP are providing financial support and administrative resources to the practices. All sites have "embedded" care managers	$24 pmpm for chronically ill	Incentives for quality, patient experience, and efficiency
Hudson Valley	HEAL-NY grants to assist with EMR implementation. THINC funds and provides "embedded" care managers	Varies by payer, ranging from $5 to $10 pmpm	Incentives for quality, patient experience, and efficiency under consideration
Independent Health	A monthly risk-adjusted stipend is provided to participating groups to assist in the transformation of their practice to one that is more patient-centered and team- and coordination-based	Physicians receive an increased level of reimbursement once they achieve NCQA recognition. Payment for care coordination is included in our monthly stipend paid to the physician groups	Incentives for quality, patient experience, and efficiency. Minimum and maximum performance thresholds/benchmarks have been established. Additional payment is awarded to physicians/groups meeting those performance thresholds
MVP - Onondaga	$110,000	Up to $4 pmpm for NCQA Level 2, and up to $5 pmpm for NCQA Level 3	Incentives for quality, patient experience, and efficiency
Anthem/Empire BCBS	N/A	Percent increase above standard fee schedule dependent on patient attribution to a participating physician/practice	N/A

to participating practices to support practice transformation during their start-up phase and prior to NCQA recognition. In other demonstrations, they agreed to advance "care management" payments to practices for a period of time, before they were able to apply for and receive NCQA recognition. And in some, practices received no financial support to defray the costs of practice transformation or the other changes required to achieve PCMH recognition.

Funding for Ongoing Operational Costs

The methods by which the payers are supporting the incremental, ongoing operating costs of a PCMH vary among the demonstrations.

In many, payers are making care management payments to providers, based on the number of individuals covered by a given payer who have been "attributed" to a given provider. In the demonstrations, these rates range from $2.50 pmpm to $10 pmpm. In the Rochester demonstration, Excellus and MVP are paying participating providers a higher care management fee ($24 pmpm) but *only* for complex, chronically ill patients.

In other demonstrations, payers have adjusted their existing fee-for-service payment rates, paying a percentage increase on certain billing codes to providers in the demonstration who have achieved NCQA recognition. And finally, in some demonstrations, payers are using the project as an opportunity to test entirely redesigned payment systems for primary care providers, replacing per-visit payments based on CPT codes with a system of risk-adjusted capitation payments that reflects the added costs involved in caring for complex patients.

Performance Measures, Pay-for-Performance, and Incentive Payments

All of the demonstrations have specific performance measures for quality, patient experience, and utilization that they require participating providers to collect and report; and most also analyze claims data for utilization and costs. While most are using variants of the commonly accepted metrics (CG-CAHPS to measure patient experience, HEDIS measures for quality, and emergency department and hospital utilization measures as a proxy for cost) there is substantial variation among the pilots in the specific measures being collected and analyzed.

Most of the demonstrations include some manner of pay-for-performance (P4P) or incentive payment in the payment model, based on the performance of the providers in those domains. These payments, and the benchmark performance measures against which they are compared, vary substantially among the demonstrations.

Evaluations

Each of the demonstrations includes an evaluation of its impact. Some are using academically based evaluators, conducting formal, structured project evaluations, often supported by grant funds. While formal and informal evaluations of these demonstrations are still under way, early indications are that these experiments are producing the desired results in quality, patient experience, and cost control.

These demonstrations (with exception of Emblem's) are ongoing, and a number (CDPHP, CMP, MVP, and Independent Health) are presently expanding their provider base.

New York Medicaid's PCMH Initiative

In July 2010, New York State's Office of Health Insurance Programs (which is responsible for the state's Medicaid program) changed the way in which it paid primary care providers, putting into place enhanced payments under its FFS and managed care payment systems for providers who had achieved NCQA recognition.

In the FFS payment system, Medicaid gave add-on incentive payments (ranging from $5.50 to $21.25) as part of its visit payments to NCQA-recognized providers to reward that recognition. For managed care enrollees, Medicaid now pays plans an additional premium, which the plans distribute to each NCQA-recognized provider as an additional payment based on the provider's level of NCQA recognition: $2 pmpm for an NCQA-recognized Level 1 provider, $4 pmpm for a Level 2 provider, and $6 pmpm for a Level 3 provider, for each managed Medicaid member enrollee on their panel.

These payment system changes gave providers of primary care to Medicaid enrollees — including many "safety net" providers — a powerful incentive to pursue and achieve NCQA recognition. While data on the FFS experience are not currently available, the impact of these changes in payment in the Medicaid Managed Care program is compelling: as of July 2011, of the roughly 3 million enrollees in Medicaid Managed Care, nearly 900,000 (over 30 percent) now receive their primary care from a provider who has received NCQA recognition as a PCMH, the majority of them from providers who had achieved Level 3 recognition (Figure 3).

The proportion of all enrollees with PCMH providers varies substantially by plan (Figure 4).

The proportion of enrollees receiving their primary care from an NCQA-recognized PCMH provider also varies by region, across the state (Figure 5).

Figure 3. **New York Medicaid Managed Care Enrollees Enrolled in PCMHs, by Level**

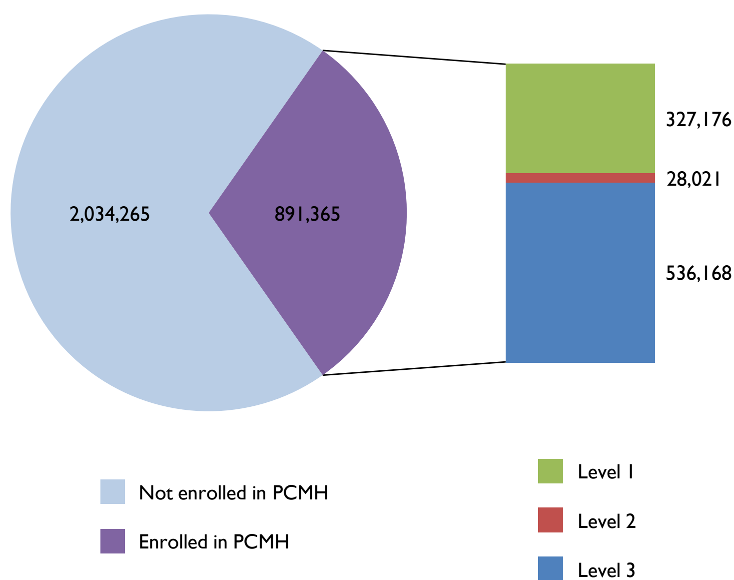
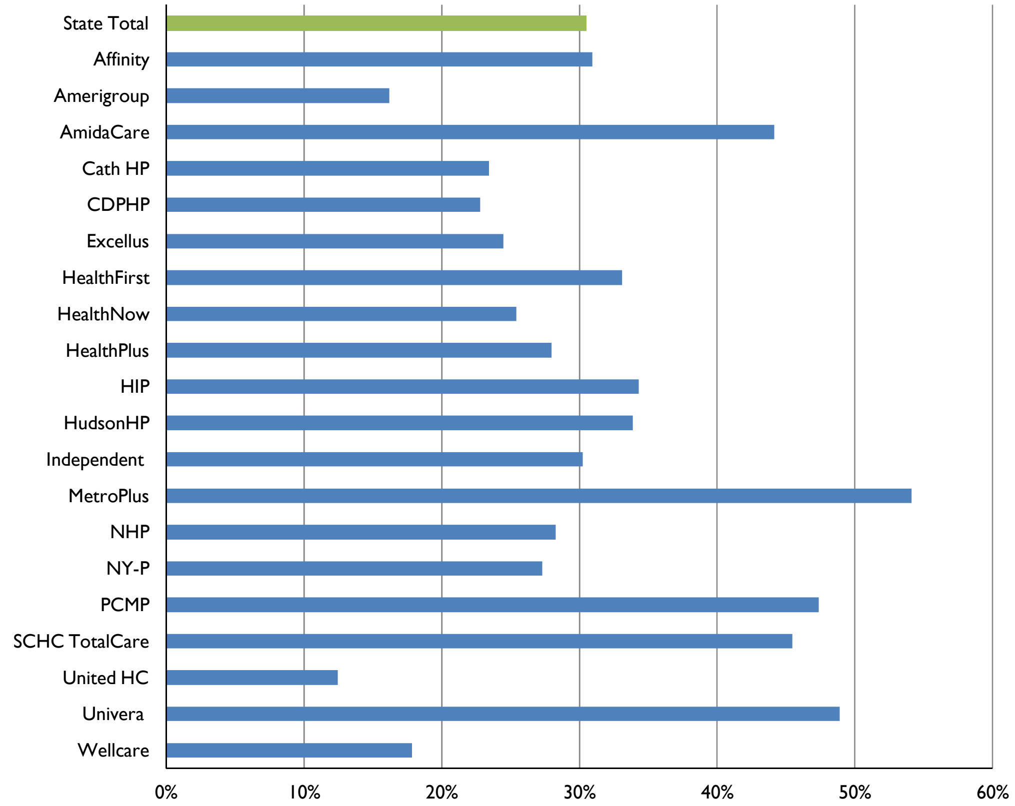
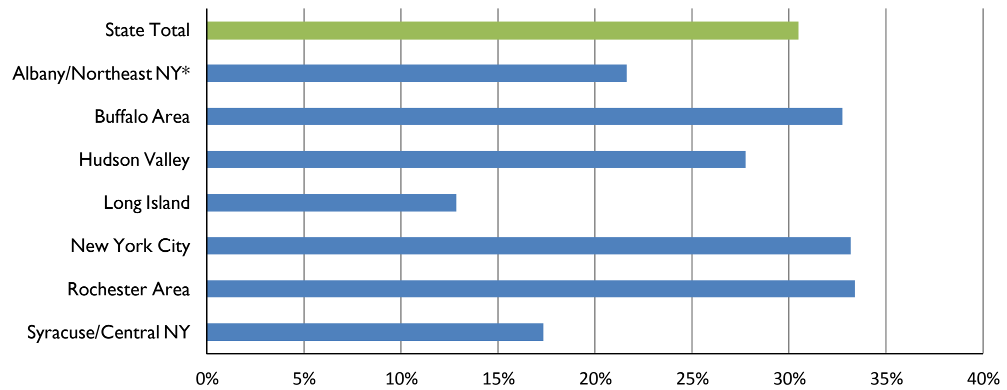


Figure 4. **Medicaid Managed Care in New York State: Enrollees With PCMH Provider as Percentage of Total MMC Enrollees, by Plan**



Note: As of May 2011. Source: Analysis by New York State Office of Health Insurance Programs.

Figure 5. **Medicaid Managed Care in New York State: Enrollees With PCMH Provider as Percentage of Total MMC Enrollees, by Region**



* Counties served by the Adirondack Medical Home Demonstration are not included.
Note: As of May 2011. Source: Analysis by New York State Office of Health Insurance Programs.

NCQA Recognition

An overall measure of the adoption of the PCMH model by providers across the state — which subsumes both the demonstrations and the Medicaid initiative — is the total number of providers who have sought and received NCQA recognition.

To conduct this analysis, United Hospital Fund staff requested and received from NCQA a file that included all New York State providers who had received NCQA recognition as PCMHs as of July 31, 2011. That file included the provider name, practice site, ZIP code, and level of NCQA recognition.

Analysis of this file identified a total of 3,741 providers in the state who had received NCQA recognition as a Level 1, 2, or 3 PCMH, by far the largest number of NCQA-recognized providers of any state in the country. Of the NCQA-recognized providers in the state, 875 were recognized as Level 1 PCMHs, 274 as Level 2, and 2,592 as Level 3 (Figure 6).

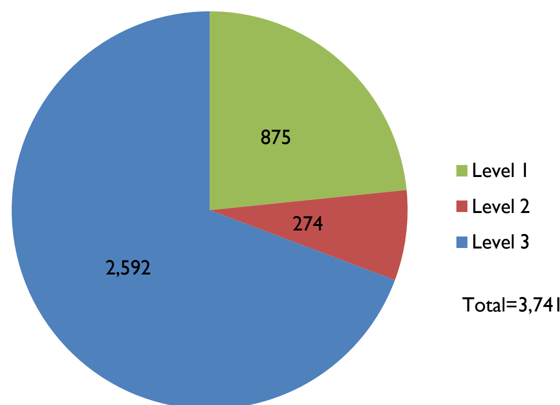
Regional Distribution of NCQA-Recognized Providers

We reviewed the geographic distribution of NCQA-recognized PCMHs across the state, using an aggregation of the regions used by the New York State Department of Insurance. As shown in Figures 7 and 8, the number of NCQA-recognized PCMHs varies widely by region, both outside New York City and within the city (by borough).

NCQA-Recognized PCMHs as a Proportion of All Primary Care Physicians

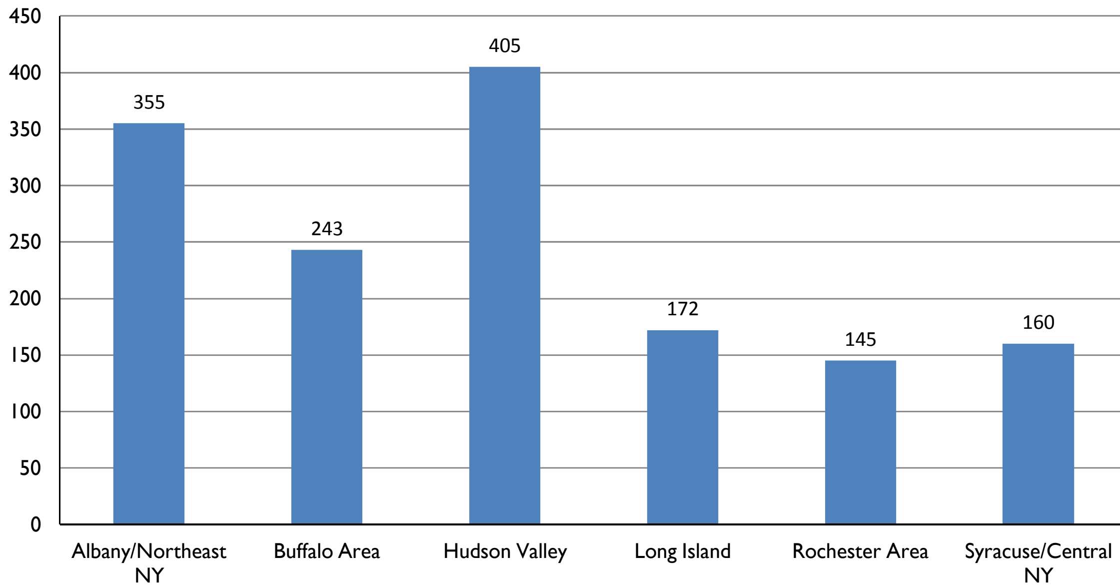
Using data from the New York Center for Health Workforce Studies (CHWS) on primary care physicians by county, we assessed PCMH providers as a proportion of all primary care physicians within a given region. This analysis indicated that for the state as a whole, 18.5 percent of all primary care physicians appear to have sought and achieved NCQA recognition as PCMHs, but there is considerable

Figure 6. **NCQA-Recognized Providers in New York State**



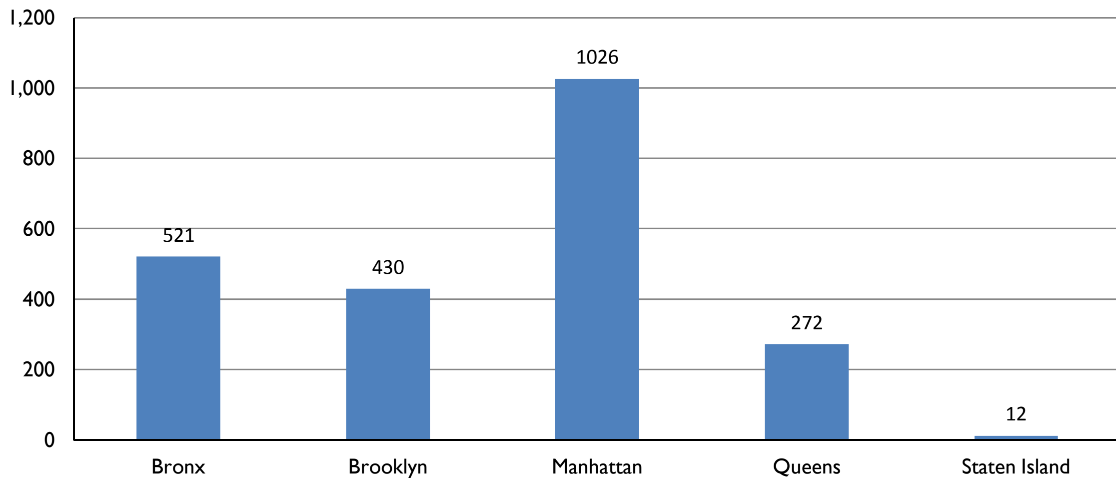
Source: UHF analysis of NCQA provider files for New York State as of July 31, 2011.

Figure 7. **NCQA-Recognized PCMH Providers in New York State (Excluding NYC), by Region**



Source: UHF analysis of NCQA provider files for New York State as of July 31, 2011.

Figure 8. **NCQA-Recognized PCMH Providers in New York City, by Borough**



Source: UHF analysis of NCQA provider files for New York State as of July 31, 2011.

regional variation across the state in the "penetration" of NCQA recognition as a proportion of all reported primary care physicians. As expected, this phenomenon tracks reasonably closely with the presence of PCMH demonstrations (Figure 9).

NCQA-Recognized PCMH Providers by Practice Type

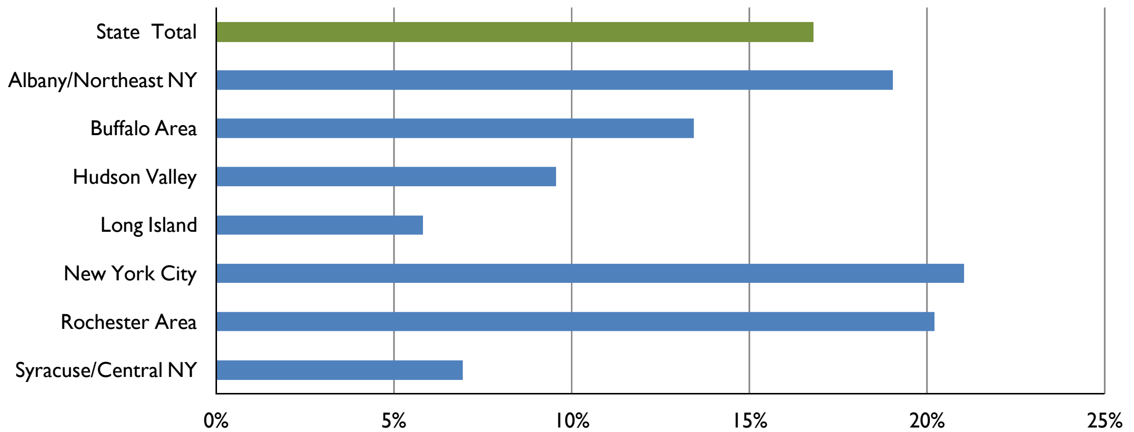
Using the "practice site" information provided by NCQA, we assigned each of the PCMH providers to one of six "practice types":

- Solo or small group practice of less than 10 providers ("Small Practice")
- Larger group practice ("Group")
- Hospital- or academic medical center-affiliated faculty practice or group ("Hospital/AMC Practice")
- Community health center, including FQHCs ("Health Center")
- Hospital-based primary care clinic ("Hospital Clinic")
- Health and Hospitals Corporation ("HHC") was separated out for specific focus, because of its size, and its level of participation in the NCQA recognition program

Overall, the picture that emerged from this analysis of the NCQA-recognized providers by practice type was somewhat surprising (Figure 10). Large groups and health centers were the two largest components of the state's NCQA-recognized PCMHs, the majority having received Level 3 recognition. Hospital and AMC-affiliated practices were the next-largest cohort, but they were less likely to have achieved Level 3 recognition. HHC as a system stood out among the hospital-based clinics: most providers in its primary care clinics have received recognition, and all of those at Level 3. Physicians in solo and small practices represented a surprisingly large cohort, due at least in part to their participation in the PCMH demonstrations. Non-HHC hospital-based clinics were the smallest cohort, and they were far less likely to have achieved Level 3 recognition.

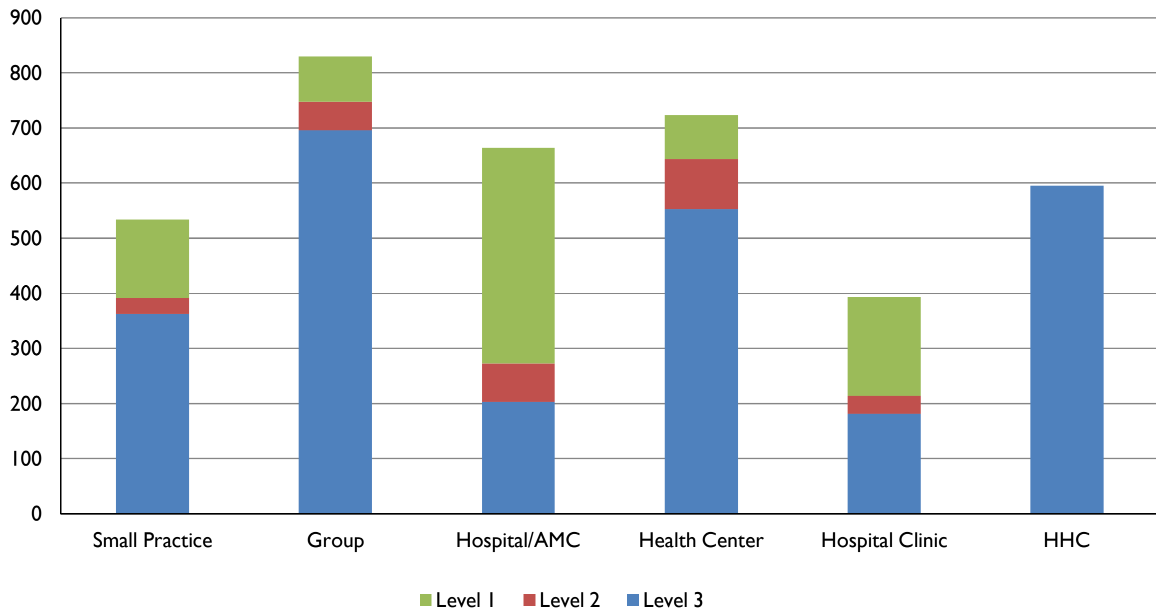
Two initiatives are now under way to help hospital teaching clinics — an important source of primary care in New York State, particularly in New York City — to transform their care delivery model. The Greater New York Hospital Association is now leading a multi-year initiative to help redesign care processes in these clinics, to improve care and enable them to achieve medical home status; and the State recently received federal approval of the Hospital-Medical Home demonstration, under which it will provide up to $325 million to hospitals to help support their adoption and implementation of the PCMH model in their teaching clinics.

Figure 9. **NCQA-Recognized PCMH Providers in New York State as Percentage of Total Primary Care Physicians, by Region**



Source: UHF analysis of NCQA provider files for New York State as of July 31, 2011 and New York State Center for Health Workforce Studies, Primary Care Physician Counts by County, 2010.

Figure 10. **NCQA-PCMH-Recognized Providers in New York State, by Practice Type and NCQA Level, as of July 31, 2011**



Source: UHF analysis of NCQA provider files for New York State as of July 31, 2011.

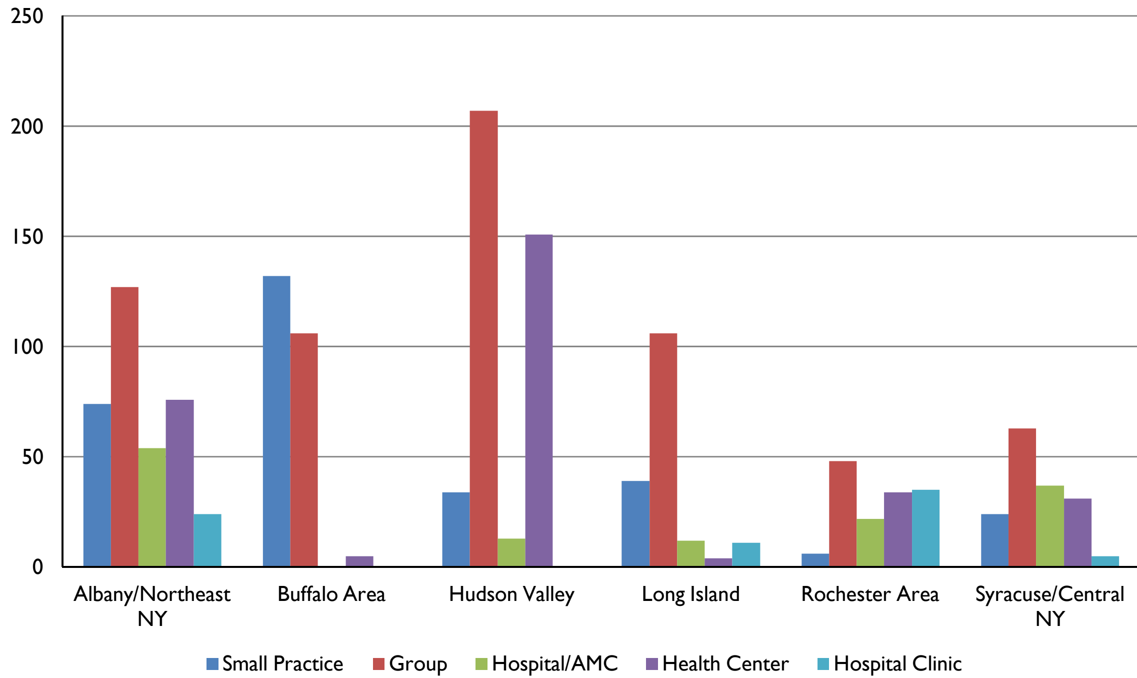
NCQA-Recognized PCMH Providers by Practice Type and Region

Finally, we looked at PCMHs by practice type and region, which provided another perspective on the composition of the regional PCMH census. This, like the basic profile by region, reflects participation in the demonstrations; but it also provides insights into the composition of the provider base and the distribution of provider types in those regions.

As is shown in Figures 11 and 12, there are some striking differences among the regions in the composition of the PCMH providers:

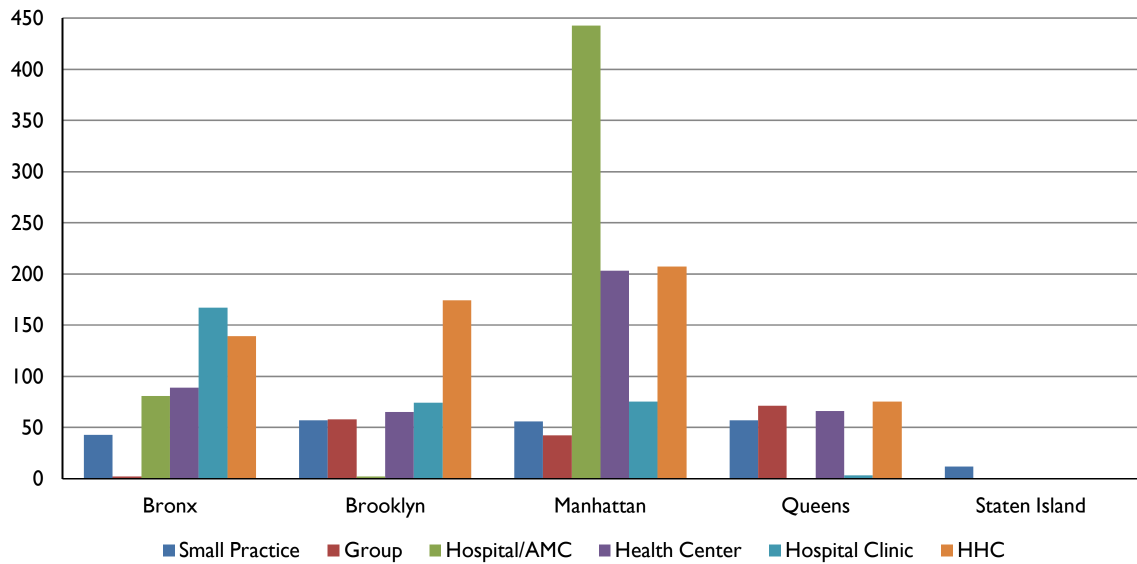
- Outside of New York City, the biggest cohorts of PCMHs are large group practices, followed by health centers, which are major participants in two of the PCMH demonstrations (Hudson Valley and the Adirondacks). Small practices are meaningfully represented in Buffalo and Albany/Northeast New York regions, where they participate in PCMH demonstrations.
- In New York City, large groups are less of a force; practices based in hospitals academic medical centers (a unique and important provider type, particularly in Manhattan), HHC, and community health centers are the largest cohorts.

Figure 11. **PCMHs by Practice Type, New York State (Excluding NYC), by Region**



Source: UHF analysis of NCQA provider files for New York State as of July 31, 2011.

Figure 12. **PCMHs by Practice Type, New York City, by Borough**



Source: UHF analysis of NCQA provider files for New York State as of July 31, 2011.

Discussion

The Patient Perspective

The Patient-Centered Medical Home starts with the patient. There are three core elements to the PCMH that relate directly to the patients themselves: market segmentation and product design, care management, and patient engagement.

Product Design

In business, product design is based on an understanding of the major market segments being served and their specific needs. The core principle is that the best products are the ones that best address those needs. While the PCMH was not the product of a conscious industrial product design process, with its sharp focus on responding to the needs of specific subpopulations of patients (the "market segments"), it might as well have been.

Not all patients are alike. Any given practice is composed of different kinds of patients, who have some common needs and other unique ones.

In general, patients and their families want their care to be easily accessible and of high quality, and to have a meaningful, long-standing relationship with "their" providers, who know them and their health problems, help them to maintain wellness, and coordinate their care, as required. They also want the expense of their care to be reasonable. The PCMH model has value for all patients served, in improving care quality and patient experience and in reducing the costs of care.

The real innovation in the PCMH, however, is its ability to respond effectively to the needs of the three different subpopulations of patients, who have different expectations and needs and who use the health care system differently: the "well" and those whose potential health problems are under control; those with an acute episode involving admission to a hospital; and complex, chronically ill populations and their families.

The PCMH model combines many of the currently recognized "best practices" in providing primary care: its components include "Advanced Access," Transitions Management, the Chronic Care Model, and the use of registries and care management. With these capacities in place, the PCMH has the potential to respond effectively to the needs of each of these three subpopulations.

- The "Well" tend to be mainly interested in access, support for wellness and health promotion to maintain their health and function, and rapid, well-coordinated access to needed specialty ambulatory care, when the need arises. The PCMH responds well to these needs. With its focus on improving access and on the application of evidence-based approaches to control and manage early-stage chronic diseases, the PCMH can also delay or prevent their progression to more advanced illnesses, thus reducing the number and care costs for this population, going forward.
- The acutely ill have the same concerns as the "well," but they also have a specific interest in the quality and safety of the acute care being provided, in the seamless coordination of care among specialists, and in the management of care transitions. With its focus on care coordination and support of patients and families during care transitions, the PCMH addresses these needs too.
- Complex, chronically ill populations and their families have a specific interest in (and a particular need for) a solid, long-term relationship with a provider who knows them, who understands them and their needs, who helps them manage their

problems (which can be numerous and can span both medical and social services fields) and helps them navigate a complex care system and to manage their chronic illness. The PCMH responds to the needs of these high-risk/high-cost patients and families through its focus on population health, the creation and use of registries, and the application of evidence-based care, coupled with an emphasis on two "new" functions: ongoing care (and relationship) management, and patient education and engagement.

The PCMH's ability to address the needs of these three different market segments has underpinned its success to date. However, it has particular value for patients and families whom the current health system serves least well, and at the highest cost: those with multiple complex chronic conditions and those facing potentially disruptive and dangerous care transitions.

Care Management

A core competency of the PCMH is its ability to coordinate care provided within the primary care practice, to coordinate care provided to patients using specialists and hospitals, and to manage their patients' care, across the continuum. This is important for any patients who are referred for specialty care or are hospitalized, but it is critical for managing populations of chronically ill patients, who often use multiple specialists and frequently interact with providers of mental health and social services as well.

PCMHs have developed capacities for care management, with staff specifically focused on that activity (variously referred to as "care managers," "care coordinators," "navigators," and the like). These staff are supported by specifically designed systems, including registries to identify, stratify, and track patients with specific health, mental health, or social service needs; and systems and processes (including phone and internet contact, home visits, and in-home monitoring) to monitor their status and care needs, and to identify "gaps" in care requiring attention.

One particularly important element in the care management process is its human face: the establishment of meaningful, longitudinal, supportive personal *relationships* between the patients and an individual on the care team (the care manager) who knows them, understands their problems and assets, and has clear responsibility for providing them and their families with ongoing assistance in navigating a complex care system, and with specific assistance when they are facing particular problems, such as care or life transitions.

Patient Engagement and Support

Another of the PCMH's core values is its focus on engaging patients and families in the care process. Engaging patients and families as effective partners in the care process, involving them in decision-making, and providing support at critical points in the process (e.g., care transitions, and near the end of life) have been critical to the model's success. They also require a real change in the historical roles of both patient and provider.

Providers need to be aware of and responsive to the needs of patients and families, to teach them about their health, their health problems and their role in maintaining (or regaining) wellness; to provide them with the tools and approaches required for chronic disease self-management; and to provide them with care coordination and support across the care continuum. This requires some new people and new functions in and around the primary care setting, but it also requires a new approach and mindset.

Patients and families need to understand and embrace a larger role as partners in the care process, learning more about their health, the diseases they have and their treatment, and what they need to do and watch for. They need to know when to call, and whom to call, when they need

assistance and advice. And they need to adjust their expectations, moving from a passive to an active role, recognizing the way their own behavior (diet, exercise, smoking, and adherence to therapy) affects their health, and becoming "activated" in their own care.

The PCMH encourages patient engagement in its "product design," and it regularly assesses the patient experience, measuring how effectively it meets those needs and responds to those concerns, and then using that information to help inform program operations.

Ultimately, the success of the PCMH will be determined by its ability to establish and maintain meaningful relationships with patients and their families, to provide them with needed advice and support, and to help them navigate a care process that includes other providers and services in the communities.

The Provider Perspective

Even though the PCMH can be a challenge to implement (see the section "What a PCMH Does," above), for most primary care providers the appeal of the PCMH model is quite basic: it just seems to make sense, from a number of different perspectives. It has the potential to improve the quality of care they provide, enabling them to better respond to their patients' needs. It can improve quality, continuity, and patient experience. It can help reduce costs for today's high-cost chronically ill, while reducing the likelihood that those currently at risk will become tomorrow's.

The model can also improve the quality of providers' work life and ensure that they are paid more appropriately for their efforts, and increase the attractiveness of a career in primary care to young physicians entering practice, which may help redress the longstanding problem of inadequate primary care capacity.

In principle, if primary care providers can transform their practices to the PCMH model, the purchasers, payers, and state and federal governments should be supportive. That means addressing some of the basic issues that providers face when implementing the PCMH in their practices, and when sustaining the PCMH in an environment that is still dominated by the fee-for-service payment system.

Which Elements of the PCMH Model Really Make a Difference?

The PCMH has many value-added attributes, not all of which are of equivalent value or impact; and their value may depend on the patient population under consideration. Providers implementing the PCMH model need to consider which of those attributes are truly critical and whether there are certain "core" functions and activities within the PCMH model that really make the difference for the most at-risk patients in improving quality, lowering costs, or both.

It is reasonably clear that expanded access, the creation of effective care teams, better coordination of care across the continuum, and a robust quality improvement program focused on the application of evidence-based medicine will together produce better and safer care, and improve the experience of care for all patients.

It is also increasingly evident that two "patient-facing" functions of the PCMH are of particular value in caring for the chronically ill: care management and patient engagement. These are capacities not usually present in the traditional primary care practice, which need to be developed, supported, and embedded in the practices, with staff acting as effective members of the care team.

There is great interest in both care management and patient engagement, but some issues still need to be resolved:

- The functions themselves are broad, and there needs to be clearer definition of the range of different services they each include.

- There remains a diversity of opinion regarding the levels and types of staff who should be providing these services (staff involved in care management range from nurse practitioners to community health workers) and what core competencies are required.
- There remain challenges in training, certifying, and deploying care managers, and in resolving a series of important management issues (who employs them; who pays for them; to whom should they report; if they are "shared," how to allocate their time, effort, and expense).
- There is a growing but as yet incomplete understanding of the most effective techniques for care management and patient engagement: which approaches work best in which circumstances and for which types of patients.
- Similarly, there is an incomplete understanding of what it costs to develop and provide these services, and the best model for their operation (e.g., centralized or distributed), and how best to organize and pay for those services (McDonald et al. 2010).

The Need for Multipayer Participation

Implementing PCMH entails changing many aspects of a primary care practice; it represents fundamental change, practice-wide. Practices that are implementing PCMH need a critical mass of payers — "enough" payers covering "enough" of their patients to support the PCMH model, providing the resources needed to become a PCMH and to operate as one. If only one or a few of the payers support (and pay differently for) the PCMH, there may not be sufficient resources to bring about that change or to support its ongoing operating costs.

Variation in Payment, Measures, and Incentives

Under the various demonstrations, payers have used different payment methods, quality metrics being tracked and reported, and incentive payment schemes.

Providers have noted that the diversity among payers in the measures being used to evaluate overall performance (and to drive incentive payments) presents many operational and logistical challenges. It is exceedingly difficult for providers operating in a multipayer environment to track and report multiple measurement methodologies, and harder still to respond to incentives that differ from one payer to another.

Achieving some level of consistency across payers in both measures and incentives could help accelerate the implementation of the PCMH in primary care practices across the state. Regularizing the key elements of support and performance measurement requires that payers be able to work with each other and with providers. As is discussed below, standardization will not be easy to accomplish; but from the provider perspective, it is a central and critical issue.

Organizational Models for the PCMH

Implementing the PCMH represents a substantial commitment for a traditional primary care practice. It requires investment capital, new resources, a care management infrastructure, and an organizational context — again, attributes not normally associated with primary care medical practices in New York.

Organized physician groups (including FQHCs and hospital/AMC-affiliated practices) that already have in place an administrative and clinical infrastructure have a head start. Achieving PCMH recognition and capability can be a greater challenge for solo and small primary care practices, which remain important providers of care in most of

New York's rural areas and many of its urban ones. For such providers, there may be value in partnering with other providers, using a "shared-services" model (Abrams, Schor, and Schoenbaum 2010).

The shared-service, shared-governance model (being used in the Adirondack, Hudson Valley, and CMP/Buffalo demonstrations, and emerging more broadly across the state) represents a potentially promising vehicle to help providers to work with multiple payers to adopt common PCMH standards, clinical and other measures, payments, and incentives, and to develop and provide to its members a range of PCMH-critical capacities that are not affordable by small practices. These services include EMRs and health information technology training and consulting, programs of patient health education, care management, financial management expertise, and support for quality improvement and data reporting.

However, creating and sustaining such multi-provider vehicles is not likely to be easy. Providers and the systems with which they are associated are often competitors, and there are real issues of governance and decision-making, trust, and legitimacy to be addressed, as well as a need to be able to build, manage, and support the clinical, administrative, and financial infrastructure and IT capacities that truly add value.

Similar Terminology, Different Care Models

The terminology being applied to various care models and approaches is creating some understandable confusion.

Different, overlapping terms are being used by different accrediting organizations and by federal and state agencies for their versions of the "medical home" and different initiatives — often with their own criteria for what a medical home is and must provide. One such initiative is the recently announced "Comprehensive Primary Care" (CPC) program, a new CMS-led multipayer initiative very similar to the PCMH that provides a new and promising vehicle through which Medicare can work with private payers and states to improve primary care.

In addition, similar terms are being used for programs that are quite different from one another. One example is the implementation in New York of the "Health Home" program created in the Affordable Care Act, which is creating some confusion among providers. ("What is a health home, versus a PCMH?")

The Health Home has many of the same elements of care as the PCMH, but its focus is slightly different: where the medical home focuses on the transformation of an entire primary care practice (improving care for all patients in that practice), the Health Home focuses on coordinating and managing the care of the most complex subpopulation in the Medicaid program: the multiply, chronically ill, whose medical problems are often overlaid with serious mental health and substance use issues and social service needs.

The Health Home program is an important initiative by New York Medicaid to organize and manage care for a specific subpopulation of the most complex and at-risk Medicaid enrollees: patients who are the most complex, and who generate exceptionally high Medicaid costs, evocative of those described in Atul Gawande's "Hot Spotters" (Gawande 2011). Under the Health Home program, the state will pay augmented rates to approved providers who offer intensive care management to coordinate service delivery to this population, whose needs often span the medical, behavioral health, and social service delivery systems.

At their core, all of these programs share many, if not most, key program elements. The question is whether the proliferation of new accreditors and new definitions will help or hinder the expansion of the PCMH model nationally or in New York.

Provider Supply

Many communities across New York State do not today have enough primary care providers. There is a growing appreciation of the need to address this ongoing supply problem through programs to increase the training of primary care physicians, to encourage them to practice in parts of the state that have real and pressing shortages, and to provide adequate resources to sustain them.

The PCMH, with its effective care teams (often including nurse practitioners and physician's assistants), may have the ability to improve the effectiveness and capacity of the existing providers to manage populations of patients. But it is not clear that the PCMH model alone will be sufficient to address the absolute deficits in provider supply in many areas of the state.

Beyond the PCMH: the Need for a "Medical Neighborhood"

Lastly, it is not yet clear whether primary care providers organized as PCMHs will have sufficient leverage to effect adequate and sustainable system change by changing the behavior of specialists and hospitals who drive much of the health system's preventable costs. Other, wider changes are likely to be required: a set of partnerships that would situate the "medical home" in a "medical neighborhood."

- PCMHs must partner more effectively with hospitals, home care providers, and long-term care providers to improve the management of care transitions and reduce preventable readmissions.
- Better coordination between the PCMH and specialists is needed to provide improved access to needed specialty care, and to better manage and control its overuse.
- Better integration of the PCMH with providers of behavioral health care is clearly needed to manage the often co-occurring problems of physical and mental health, and substance use.
- Particularly for the chronically ill, PCMH services need to develop effective partnerships with community-based providers of social services.
- Crafting such partnerships across the FFS-reinforced care silos may lead to a blurring of the boundaries among health providers, and ultimately to a consideration of the need for more extensive reimbursement reform.

The need to move away from a volume and specialist-preferential FFS payment system is clear. The system needs to move toward aligning payments with the Triple Aim — to improve quality, experience, and population health, and reduce preventable utilization and cost — in order to achieve the potential of the PCMH model.

The Purchaser and Payer Perspective

The organization and function of the current health care delivery system did not happen by mistake; it is a rational response to payment systems and incentives that have grown up over the past five decades. If the PCMH model is to succeed, the way primary care providers are paid for delivering those services must change.

Changing the payment system to support a change in the way services are provided, however, is not a simple undertaking. For payers to support it, they must be convinced that it will improve the quality and the experience of care for their members, that it will reduce costs, and that it will ultimately enable them to compete more effectively.

There is general agreement that to the extent that the PCMH represents value, purchasers and payers should recognize and help support those transitions, and ongoing operating costs; and that, if possible, payers should align their

payment policies and systems to reward that change, in some consistent way, so that providers have a consistent set of standards, measures, and payments.

However, payers operate in a very complicated environment, and changing payment systems and engaging in multipayer partnerships are not simple undertakings. These require technical changes (what to pay for, and how); changes in the relationships among otherwise competing organizations; and changes to the regulatory system within which payers operate.

Paying Differently for PCMH

The *Joint Principles* recommend that a PCMH payment structure should be based on a framework (see inset box) that recognizes and pays primary care physicians in a manner quite different from the current FFS system.

In New York State, payers are using a variety of different techniques to pay for PCMH services. Some are paying care management fees of varying levels for all members cared for in a PCMH; others are targeting those payments to specific populations; some are adjusting fees used under traditional FFS payment schedules; and some are using entirely redesigned payment techniques.

Paying differently for PCMH is a challenge for payers, many of whom have legacy claims payment systems that are difficult to alter for new types of services. Many have been forced to use patchwork techniques, developing new payment codes or adjusting payments under their FFS system methods simply to move ahead.

Achieving Consistency in Payment, Measurement, and Incentives

Having different payers pay for PCMH in a consistent manner is important to providers, who generally serve panels of patients insured by a number of different payers. This represents a real challenge to the broader rollout of the PCMH model across the state.

Similarly, achieving multipayer agreement on a common set of standards, measures, and incentives will not be easy to achieve or to sustain. Payers live in a competitive environment, each striving to gain and maintain market share. They place an emphasis on differentiating their products, and on demonstrating their unique value to potential purchasers.

Excerpt from the *Joint Principles of the Patient-Centered Medical Home*

Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure should be based on the following framework:

- It should reflect the value of physician and non-physician staff patient-centered care management work that falls outside of the face-to-face visit.
- It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources.
- It should support adoption and use of health information technology for quality improvement;
- It should support provision of enhanced communication access such as secure e-mail and telephone consultation;
- It should recognize the value of physician work associated with remote monitoring of clinical data using technology.
- It should allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits).
- It should recognize case mix differences in the patient population being treated within the practice.
- It should allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting.
- It should allow for additional payments for achieving measurable and continuous quality improvements.

Source: http://www.pcpcc.net/content/joint-principles-patient-centered-medical-home

Doing things that are similar to (or the same as) other payers reduces their ability to do so.

In addition, the regulatory environment in which payers exist has not historically been supportive of multipayer cooperation. Having payers come together to agree on consistent ways of defining products, sharing pricing information, setting standards for payment, and designing consistent incentive plans is generally considered anti-competitive behavior, subject to antitrust sanctions.

In recent years, New York has taken steps to reduce this exposure, providing "state action immunity" to payers participating in state-sanctioned and state-supervised multipayer PCMH initiatives, first for the Adirondack demonstration and more recently on a statewide basis. That antitrust protection does not, however, provide complete immunity from federal oversight and sanctions. The process of gaining that state-level protection is also quite challenging and, to date, no other areas in the state have pursued or achieved it.

Methods for Supporting and Providing Core Services

In the demonstrations, there has been remarkable diversity in the way care management, patient education, and patient engagement are supported and provided.

Over the past decade, payers have developed in-house care and disease management capacities, and a range of health promotion, health education, and wellness services, in part to reduce preventable utilization and cost of their members, and in part to differentiate their product and demonstrate their value to purchasers.

There is increasing appreciation, however, that these services need to be closer to the delivery system, to be available to the providers and members of their care teams at the point of care. How that is accomplished in the demonstrations has been quite variable.

In the single-payer demonstrations, payers have begun to migrate those services to the primary care settings. A number have chosen to pay for those capacities, supporting the costs of care managers and health education/patient engagement staff, and embedding them in the participating practices, focusing in general on their own members.

In the IPA/shared-service models, the provider organizations have taken on that role, accepting payments from the various payers, and developing those capacities as shared services, embedding them within the practices to serve all their patients.

If, as is increasingly apparent, these are services critical to the performance of a PCMH, there should be a more consistent method for developing and delivering them to the practices, and for paying for and supporting them in PCMH practices.

The Role of the Purchaser

Purchasers of care (employers, unions, and government bodies, an increasing number of which are self-insured) are a potentially powerful force for change, though as yet they are not completely engaged.

In New York, a substantial number of the self-insured purchasers use commercial payers (operating in an "administrative services only," or ASO role) to manage their health benefits, retaining the right to decide on benefit coverage, themselves. ASO arrangements represent a large and growing part of the payer business — as much as half of their business, in some communities.

Such arrangements can complicate the implementation of a multipayer initiative. Payers paying a separate care management fee to PCMHs for their insured populations are understandably hesitant to do so for their self-insured enrollees (spending the self-insured purchaser's money) without the purchaser's explicit approval. This was an issue in the Adirondack Demonstration (Cavanaugh and Burke 2010), where

some of the participating payers decided to exclude many ASO enrollees from the pilot. In addition, many of the self-insured purchasers use other organizations ("third-party administrators" or TPAs) to manage their health benefits. To date, these organizations have not been participants in any of the nine PCMH demonstrations.

If purchasers can be convinced of the value of the PCMH model, they can help shape that change and accelerate its adoption. Purchasers can encourage the payers, ASOs, and TPAs with which they work to include PCMHs in their networks and pay them differently; and they can encourage their employees and members to enroll in PCMHs.

If the state's major employers and union benefit funds can align with the payers and providers already involved in PCMH demonstrations to support the spread of the PCMH, they can create substantially more support for the expansion of this model statewide.

Summary and Open Issues

Over the past five years, there has been increasing adoption of the PCMH model by payers, providers, and purchasers across the country, as evidence mounts that it is an effective care model that can improve quality and patient experience while reducing preventable utilization and cost. Over that time, New York State has seen a major expansion in the adoption of the PCMH model as a way to organize primary care. This has been stimulated by three forces:

- the conduct of a number of pilot and demonstration projects, involving payers and primary care providers across the state;
- the implementation by Medicaid of a new payment model, augmenting payments to providers who have been recognized as PCMHs; and
- the broader adoption of the PCMH model by providers, because of the model's appeal or in anticipation of changes in payment policies.

By national standards, the expansion of the PCMH model in New York has been extraordinary. In fewer than five years following the promulgation of the *Joint Principles*, nearly 20 percent of New York's primary care providers have achieved recognition by NCQA as PCMHs, and most of the state's major payers are involved in one or more PCMH pilots or demonstrations.

This is a real achievement. Looked at differently, however, *only* 20 percent of the state's primary care providers have achieved such recognition; over 80 percent have not. And, while most of the payers are involved with PCMH to some extent, so far they have done so in a measured way (with the exception of Medicaid, which has essentially adopted the PCMH as its standard of care).

New York is now approaching a decision point. While the pilot and demonstration programs intended to assess the value of the PCMH model are beginning to produce results, and the evidence seems to be trending positive, these are still ongoing "experiments." Meanwhile, across the state, the adoption of the PCMH model has grown substantially and appears to be continuing.

The question is whether the PCMH should remain for some additional time a pilot or demonstration phenomenon, or whether the time has come to embrace the PCMH as a mainstream model of care, to be planned for, supported, and encouraged across the state.

First and foremost, there is a need for clear, compelling, and unambiguous evidence that the PCMH model does, in fact, work. Evaluations of PCMHs are under way across the country (and across New York State), and while evidence is emerging that the PCMH model can and does improve the quality and patient experience of care while containing if not reducing costs, there is not yet an evidence-based consensus as to the extent of its value and impact.

Producing and collating the evidence from the state's pilot and demonstration projects will be important, as it will contribute to the literature and help us understand the impact of this new care model in New York. However, this is an issue that is playing out at a national level, and it will likely require a broader, evidence-based consensus among providers, payers, purchasers, and regulators before there is enough support to move from pilot program to full-scale adoption.

If the PCMH demonstrations across the country and across New York continue to produce positive results, at some point in the near future we will need to ask what it will take to move from demonstrations to full-scale implementation. The range of stakeholders will need to grapple creatively with the following formative issues.

A Critical Mass of Providers

The providers who have pursued and achieved NCQA recognition as PCMHs to date — the "early adopters" — are a very specific group, who appear to have pursued that course for a variety of different reasons. Those not participating — the 80 percent who are, so far, "non-adopters" — are in many ways a different group, and their reasons for not doing so are also varied. We need to understand this latter group better — why they are not yet moving toward the PCMH model, and what it would take to get them there.

A Critical Mass of Payers

The broad participation of the state's payers in PCMH pilots and demonstrations is impressive, indicating the payers' interest in the PCMH model. However, with the exception of Medicaid, these efforts are largely limited experiments, testing to see whether PCMH works for them, with a selected subset of their own providers. Moving from demonstrations to a large-scale change in the payment system for primary care will not be easy. Payers will need to pay more for primary care provided in a PCMH, and to change their payment systems. To do so they will need to be confident that the PCMH model really works, that it can improve quality and their members' experiences of care, and that it saves money — more than they are investing.

In some communities there may be sufficient concentration in one or two payers that single-payer efforts can stimulate broad system change; but in most parts of the state, multipayer approaches will be needed to provide support for PCMHs. Payers will need to find ways to work together to gain the amplitude required to stimulate the adoption and provide ongoing support for PCMHs in communities they serve.

A multipayer arrangement is complicated to organize and manage, raising both business and legal issues; but it may be the best vehicle available for achieving the provider-desired regularization of standards, payments, measures, and incentives (Cavanaugh and Burke 2010).

The Participation of Medicare

The PCMH is particularly well designed to manage the care of complex, chronically ill patients, a high-cost population that is heavily represented among Medicare's enrollees. It is a model that makes sense for Medicare. Medicare is also an enormously important payer, representing a substantial portion of every adult physician's panel, volume, and income.

While Medicare is participating in the multipayer pilot project in the Adirondacks, it is not currently part of any other PCMH demonstration in the state. Medicare's participation in projects focused on increasing the adoption of and support for the PCMH in New York will be important, if not critical, in achieving scale.

The Importance of Standardization

Providers continue to stress that they cannot respond effectively to approaches to PCMH that vary from one payer to another. There is a real need for payers to "regularize" standards, payments, measures and incentives for to the PCMH.

The Measures Themselves

While it is possible to measure and report on an increasing number of outcomes and characteristics, those currently used as PCMH performance measures are limited, and largely measures of process. There are a number of open questions about how best to improve those measures and processes.

Are the various PCMH measures meaningful in helping to improve clinical quality, patient experience, clinician and staff satisfaction, and office systems? What would be meaningful outcome measures and how far are we from having them?

Most PCMH providers are using the Hospital Consumer Assessment of Healthcare Providers and Systems Survey. Is this a meaningful measure with the PCMH? How do we assess whether the PCMH has had a positive impact on patients?

How can we best get and analyze meaningful measures of utilization and cost savings, which are mainly resident in payer claims databases and are difficult to collate at a provider level? Is a multipayer database essential for that task?

Finally, what data or evaluations do we need in order to "declare victory" — i.e., to demonstrate conclusively PCMHs' value and to encourage its adoption as a standard of care?

The Role of the State

New York's success to date in adopting the PCMH model has been due, in no small part, to the State's commitment and its willingness and ability to invest in that expansion. The State has invested capital and operating funds under the HEAL-NY program, under other grant programs, and from the Medicaid program, and it has used the market power of its Civil Service benefits program to stimulate and support the adoption and spread of PCMH across New York.

As important, if not more so, the State has invested time and effort of key staff from the Department of Health and Office of Health Insurance Programs, from the Department of Insurance, and from the General Counsel's Office to provide leadership and support this initiative. It has worked with the legislature on a series of key actions (including providing antitrust protection for payers participating in multipayer programs) critical to expansion of the PCMH model across the state.

The leadership and ongoing involvement of the State Departments of Health and Insurance have been critical to the success of the state's PCMH initiatives to date. However, those departments are currently involved in a number of other major and important initiatives. Given those other time-critical priorities, it is unclear whether the State will have the capacity to continue providing that level of leadership and guidance to support the larger scale and broader implementation of the PCMH model in the future.

Where Does PCMH Fit into the State's Longer-Term Strategy?

As New York focuses on the key priorities of health reform (i.e., to achieve real, near-term improvements in quality and reductions in cost), the PCMH represents an important state initiative. Evidence suggests that there are considerable and achievable near-term savings to be gained from better managing the care of high-cost, chronically ill populations. The PCMH seems to be able to achieve those savings, in addition to providing other benefits of longer-term value, in primary care.

As it is supporting the expansion of the PCMH, however, the State is simultaneously experimenting with other, more targeted interventions (notably health homes, behavioral health organizations, and managed long-term care) focused specifically on improving the quality and reducing the costs of care for high-need, high-cost and chronically ill patients.

Over the next few years, as the State pursues a range of different approaches to both payment and health system reform, including the creation of accountable care organizations, there will be a need to clearly articulate how these diverse elements all fit together.

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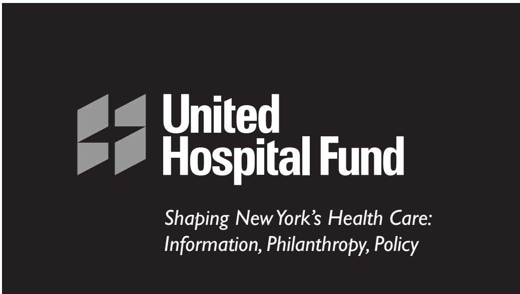
Additional copies of *The Patient-Centered Medical Home: Taking a Model to Scale in New York State* may be downloaded, at no charge, from the United Hospital Fund website, www.uhfnyc.org.



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